SPECIAL NEEDS PRESCRIPTIONS AT THE JOHNS HOPKINS HOSPITAL

A Management Study

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The Special Needs Prescription Program (SNP) provides free prescription medications to indigent patients. Since its inception in 1989, the program costs have increased an average of 15% per year. Last Fiscal Year, program costs reached over $230,000, representing an increase of 465% since the beginning of the program.

This project reviewed and analyzed data from the SNP Program for the months of July and August 1997. A total of 362 patient encounters were reviewed, representing 852 prescription medication orders. Each charge voucher was reviewed for patient demographics, medications dispensed and the respective costs of those medications. Descriptive statistics on the sample were obtained to document program trends and identify opportunities for immediate improvement. Next, each patient'seligibility and insurance status were verified. Several actions were implemented to reduce the program costs and instill administrative control.

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ABSTRACT

The Special Needs Prescription Program (SNP) at The Johns Hopkins Hospital provides free prescription medications to indigent patients. Since its inception in 1989, the program costs have increased an average of 15% per year. Last Fiscal Year program costs reached over $230,000 representing an increase of 465% since the beginning of the program.

The original intent of the SNP Program was to provide medications to only those patients who had applied or were in the process of applying for the State of Maryland Medical Assistance or Pharmacy Assistance Programs. However, loose administrative and financial control has resulted in deviation from the original intent of the program to include anyone who claims financial hardship. This "loose control" is the reason for the spiraling costs.

This project reviewed and analyzed data from the SNP Program for the months of July and August 1997. A total of 362 patient encounters were reviewed, representing 852 prescription medication orders. Each charge voucher was reviewed for patient demographics, medications dispensed and the respective cost of those medications. Descriptive statistics on the sample were obtained to document program trends and identify opportunities for immediate improvement. Next, each patient's eligibility and insurance status were verified. It was found that over 34% of the recipients had insurance coverage that would have covered the costs of prescription medications and that increased administrative control was needed in the program.

Several actions were implemented between July and December 1997 to initiate administrative control. A new hospital policy was written and approved, a comprehensive database tracking computer program was developed and installed, and an education plan was initiated to communicate the tenets of the new policy and critical need for fiscal responsibility. Additionally, there are several recommendations forwarded for consideration that would facilitate efforts to reduce the program's costs and enhance administrative control.

INTRODUCTION

CONDITIONS WHICH PROMPTED THE STUDY

In 1987, the State of Maryland implemented the Pharmacy Assistance Program (PA) in conjunction with the revisions made to the Medical Assistance (Medicaid) initiative. The PA Program was designed to assist financially challenged individuals who were not eligible for state sponsored Medical Assistance in obtaining necessary prescription medications at little or no cost. Since its inception, the PA Program approval procedures have been based on a detailed needs assessment that reviews both income and household size. (Current maximum income scales have been included in Appendix A.) Once an individual has been approved, a PA Program identification card is issued that is presented to the pharmacy to obtain prescribed medications. From the identification card number, the state reimburses the pharmacy for the cost of all prescribed medication less a $1 co-payment per covered service (Code of Maryland Regulations 10.45.01, 1987). Historically, the application processing time has been between one and three months, with recent increases to three and six months (F. Quarles, and S. Saville, Med/Surg Social Work, personal communication, August 11 and August 26, 1997). The prolonged waiting time for application processing has created a "gray area" of patients awaiting approval for pharmacy assistance and unable to afford the high cost of prescription medications.

Also in 1987, the Johns Hopkins Hospital, responding to increased cost control measures, eliminated Outpatient Pharmacy service at all sites in the medical system. In order to meet the demands of patients requiring assistance in obtaining prescription medications, the hospital made an agreement with several local pharmacies (currently Balmer and Freedom Pharmacies) to provide medications to patients in "the gray area."

The agreement outlined a plan for Hopkins to reimburse the local vendors up to 100% of the medication cost plus a $3 dispensing fee per medication provided using stratified eligibility categories for patients. Thus in 1989, the Special Needs Prescription Program was founded (H. Hamet, Pharmacy Department, personal communication, August 13, 1997).

Interestingly, the concept of "charity care" is not new to Johns Hopkins Hospital. The original charter of the hospital (as documented in Johns Hopkins Last Will and Testament, 1873) established the hospital "to serve the sick and the ill without regard to age, race, sex or ability to pay" (Employee Handbook p. 6). Since the Johns Hopkins Hospital is located in the inner city of Baltimore, it serves a high percentage of indigent patients. For example, FY97 discharge volume statistics document 48% of all inpatient discharges as either Medicare or Medicaid recipients. Additionally, state projections of indigent population in Baltimore County and City number over 440,000: the highest in the State of Maryland (Maryland Medicaid, 1996).

These factors combined have caused the cost of the Special Needs Prescription Program (SNP) to increase dramatically. The first year (1989) cost of the SNP was approximately $50,000. Last year, the program costs reached over $231,400. This represents a 465% increase in program costs since 1989. Very few cost control measures or statistics were gathered during the first several years of the program. However accurate measures collected over the past five years have documented a consistent 15% increase in program costs every year since 1993. This may not appear to be a significant issue when considering charity care is considered an acceptable "write off" in the Hopkins accounting system. However, in the current control structure for the SNP, the financial loss is attributed to the Pharmacy. A $231,000 loss to the Pharmacy budget for "charity care" has greatly impacted on their ability to maintain the current level of service. Adding

complexity to the Pharmacy's financial dilemma, the hospital reduced each department's FY98 budget by 15% of the previous year to achieve a total $55 million reduction. Thus, one must conclude that some measure of cost control must be initiated in order to maintain a viable SNP Program to meet the needs of the indigent population in the surrounding area of the Johns Hopkins Hospital.

STATEMENT OF THE ISSUES

In analyzing the history and status of the SNP Program, there were several issues addressed in this management re-engineering project:

1. Since the cost of the SNP has grown an average of 15% per year for the last five years, the current cost attribution method cannot be maintained. Are there viable sources of alternative or creative financing to bear the costs of the program?
2. The current control structure and policies of the SNP allows the Social Work Department to initiate and approve SNP Vouchers, but the cost burden of the program is attributed to the Pharmacy. Should the current chain of control and policies of the SNP remain the same? Is there a more equitable method of cost distribution?
3. Are the patients receiving Special Needs Prescriptions actually eligible for this service? Are there patients that have received prescriptions who have insurance coverage that would cover the cost of prescription medications but with a co-payment?
4. Is the current method of application and verifying patient eligibility for the SNP adequate?

5. Do the "process owners" (Social Work Department and Pharmacy) understand the implications of their actions and ramifications of costs control?

LITERATURE REVIEW

The literature review for this project was conducted to target four potential areas: available sources of similar projects (benchmark opportunities); clinical implications of decreased availability of prescription medications; methods used by patients to handle the high cost of medications; available sources of alternate financing. Although the sources were limited, information was found for each target topic.

Despite the unique perspective of the SNP Program at Johns Hopkins Hospital, there are several examples of similar programs in existence. In 1994, the Advisory Board Company conducted a survey of hospitals with internal pharmacy assistance programs. Two of the hospitals studied had similar programs to the Johns Hopkins' SNP. The Cummings Hospital[1](similar in both size and function to the Johns Hopkins Hospital) reported funding indigent prescription care on an income needs assessment similar to Maryland's Pharmacy Assistance Program. Their program guidelines allow the hospital to cover between 25%-100% of a patient's medication costs. However, their practices do not reflect the policy guidelines, as the reported hospital more often covered the full cost versus a lower percentage of the cost of the patient's prescriptions. Cumming's Pharmacy Assistance Program bears striking resemblance to the Johns Hopkins' SNP Program as the full cost of medications is assumed by the hospital. Incidentally, Cumming's program has been reported as the highest cost program in the study (Advisory Board Company, 1994).

[1] Hospitals profiled in the report from the Advisory Board Company were provided in pseudonym form.

Yeats Hospital reported incurring most of their patient's medication costs, as it is a city government hospital. The expectation is that the city government will reimburse these costs, but the reality does not meet the expectation. As a result, the Yeats Hospital provides medication (and usually medical care as well) with little or no reimbursement, also causing their Pharmacy Assistance Program to be classified as a high cost program. This program is also similar to the Hopkins' SNP with the necessity to "write off" charity care related to prescription medications (Advisory Board Company, 1994).

Several other hospitals in the study reported using the drug companies that supplied their respective pharmacies to provide or subsidize prescription medications for the indigent populations in their beneficiary area. By using this financing mechanism, the hospitals are able to limit their financial liability for their Pharmacy Assistance Programs. The burden of the cost of the medication only falls on the hospital when the upper threshold of financial support imposed by the respective company is exceeded. Thus the reason these programs were reported as a lower cost alternative to providing hospital funded free medications (Advisory Board Company, 1994).

When considering a new cost containment strategy for the SNP from a clinical perspective, it is important to consider whether such efforts may result in decreased availability of prescription medications for indigent patients. Both the medical staff and the social workers at the hospital have argued that any reduction in the availability of "free" prescription drugs to indigent patients will have a detrimental effect on their health, and actually cause an increase in repeat visits and admissions (S. Saville, personal communication, September 2, 1997). Interestingly, when approached for data to support their arguments, neither the medical staff nor the social workers were able to justify these claims. One physician proposed a study that would limit access to prescriptions for one

group of patients while allowing access to another group, but this idea was dismissed due to the ethical and legal implications of such a study.

While the literature does not support the notion that decreased access to prescriptions will lead to increased admissions and repeat visits, it does suggest that limiting availability of prescription drugs may have detrimental effects on the health of financially challenged individuals.

In a study conducted to determine the effects of interruption of antihypertensive drug therapy in Medicaid recipients, McCombs, Nichol, Newman, and Sclar (1994) found that those patients with interrupted therapy (86% of the studied population) consumed an additional $873 per patient in health care costs as a result of deteriorating health status (McCombs, et al, 1994). These findings must be considered in developing new costs containment strategies at Hopkins, as approximately 65% of the SNP recipients were on some form of antihypertensive therapy. Findings by Martin and McMillan (1996) also support the opinion that reduced access to subsidized prescriptions may result in negative effects on patients' health. They found that restricting access to prescription medications resulted in abrupt, permanent decreases in the use of cardiovascular and pulmonary drugs which are critical to health maintenance of patients with such diseases (Martin and McMillan, 1996). Unlike McCombs however, Martin and McMillan did not extend their research to clinical health outcomes, but recommended such research be conducted. Finally, Shulman (1991) deduced from his research that income levels are inversely correlated with blood pressure, concluding those patients with the least ability to pay for antihypertensive medications are most susceptible to negative health outcomes. He believes the federal government and pharmaceutical companies should fund programs to make medications more accessible to indigent patients (Shulman, 1991).

Related to personal financing options for medications, there have been studies conducted to document the options exercised by financially challenged individuals to obtain needed prescription drugs. Strickland and Hanson (1996) found that households unable to afford the cost of medications employed five strategies to cope with the cost: prioritizing, financing, rationing, substituting, and postponing. Of the five strategies, financing, postponing and rationing were cited as the most frequently used (Strickland and Hanson, 1996). Chubon, Schulz, Lingle, and Croster-Schulz (1994) echo these findings in their study conducted in South Carolina on financially challenged patients. They too found that patients sought credit from the pharmacy, borrowed money to pay for the drugs, rationed medication intake or simply did not obtain prescribed medications (Chubon, et. al, 1994). The implication of negative health outcomes derived from these studies is a critical factor that will be integrated into the re-engineering of the SNP program.

In February 1997, the Advisory Board Company (1997) conducted a research project to analyze the practices of providing medications to indigent patients within the Emergency Room. Their research studied seven hospitals in various locations in the East, South and Midwest. Two of the hospitals studied assumed the full cost of the patient's medications. The other five utilized alternative financing mechanisms such as agreements with local pharmacies, "hand-outs" of previously prepared take-home packages of medications, sample medications from pharmaceutical companies, and hospital charity funds. Interestingly, all programs that used a screening mechanism to determine eligibility for subsidized or free prescription medications employed the Social Work Department to conduct and complete the screening requirements. (Advisory Board Company, 1997) The practices described in this research are very similar to The Johns Hopkins Hospital Special Needs Prescription Program.

Lastly, the literature provided two independent sources for alternate financing of prescription medications other than internal funding or direct relationships with pharmaceutical companies for subsidy: The Medicine Program and Free Medicine. These companies operate as liaisons between patients and the pharmaceutical companies by providing the prescription medications directly to the patient's physician. There is a fee associated with program enrollment. The Medicine Program charges a $5.00 processing fee for each prescribed medication and guarantees that within 120 days the patient will receive medications from the prescribed list. A full refund of the processing fee is rendered if the patient does not receive the medications within the 120 day window (The Medicine Program, 1997).

Free Medicine offers a similar service, but charges a processing fee based on the total number of prescriptions. In their program, the processing fee is $19.95 for 1-5 prescriptions and $29.95 for 6-10. Again, the medication is sent directly to the patient's physician and a full refund guarantee is offered if the patient is not approved for at least one medication (Free Medicine, 1997). Patient enrollment in these programs will be considered during this project.

While these source references relate in some way to the SNP Program re-engineering project, there were no programs, processes or methods found in the literature that could be directly applied to this project. Thus, this can be considered a primary benchmark study that may be used in other hospitals facing similar challenges of providing a necessary, but expensive, service to the indigent population.

METHODS AND PROCEDURES

The scope and purpose of this project was to redesign the SNP Program to make it financially viable and beneficial to both the patients and the hospital. By doing so, the SNP will continue the mission and charter of the Johns Hopkins Hospital to provide care to the indigent population in the local area while lessening the financial strain on the Pharmacy. Because this is not a quantitative or qualitative study but a management redesign project, an implementation timeline has been included as Appendix B.

The first task included interviews with key personnel involved in the process or administering the program. This involved the points of contact in the Pharmacy, Social Work Department, Patient and Visitor Services, and Medical Assistance Office. The interviews were conducted with the goal of learning about the history of the SNP, gaining understanding of the current process involved in the administration of the program, and identifying opinions on potential areas of improvement.

The next step of project redesign was to review and revise the current internal policies of the SNP Program. The goal of this step was to differentiate between policy and practice, document the intent and purpose of the SNP Program, and formulate a document for submission to the administrative chain of control in the hospital for approval.

The data collection phase included a retrospective review of 100% of the SNP Vouchers for July and August 1997. The purpose of this review was to study the actual recipient population of SNP Vouchers and perform descriptive analysis. The goal of this step was to identify prescribing trends, develop a medication cost database for use by the personnel involved in administering the program, to project costs trends and identify potential areas for savings in FY 98, and establish a working database of recipients to study

for both eligibility for and use of the SNP Program. By collecting this information, most of the questions raised from the issues cited above were answered.

Related to the data collection and an important consideration in the redesign of the program are the policies used by other hospitals in managing special needs prescriptions. To research such policies, a telephone survey of other local hospitals was conducted to identify the practices and policies concerning the provision of or assistance with prescription medications. This benchmark information will prove vital to the implementation of the recommendations forwarded in this project, as it identifies potential sources of alternate funding for use in the SNP Program.

Lastly, a communication and education plan was developed and implemented to guide both the medical staff and social workers through the revisions in the SNP Program. Once the policies were approved by the administration of the hospital, a communication plan was initiated that will educate the staff about the new policies, procedures and purpose of the SNP. Communication techniques will include distribution of the new policy and forms, a program booklet describing the changes, an addendum to the New Residents' Handbook, an E-mail letter to all staff of the hospital on the Local Area Network, and an SNP Assistance point of contact designated in the Central Office of the Directorate of Patient and Visitor Services.

FINDINGS AND RESULTS

POLICY REVISIONS

The critical step to instilling cost and administrative controls in the SNP Program was to develop and submit valid policies to govern the practices of the personnel involved in administering the program. While this may seem to be a relatively easy task, due to the complexity and size of the organization and the number of personnel involved in the program, this effort was by far the most

difficult to accomplish. The issue of policy versus practice (what is written versus what is actually done) added a unique challenge to writing an acceptable policy that would establish administrative control. Committee meetings that were held to draft an effective policy were not productive due to conflicting practices within the current program. The draft versions of the policy were forwarded to the SNP Program points of contact in the Pharmacy, Social Work Department and Central Patient Relations Office for review and comment. The comments received ranged from a restrictive policy (provided by the Pharmacy) to a policy that reflected the current practice of generous interpretation of eligibility (provided by the Social Work Department). These comments were then used to develop a "middle of the road" policy that incorporated the strict interpretation of eligibility by the Pharmacy, but allowed prescription medication vouchers for "life-sustaining" medication. The approved policy has been included as Appendix C. The policy was then presented in committee to the key members of the Social Work Department, Pharmacy, and Central Patient Relations Office for implementation and distribution. To further establish effective administrative control and increase accountability, the "Special Needs Prescription Eligibility Evaluation" form was developed and deployed. The use of this form will allow improved tracking of voucher distribution and eligibility verification. Additionally, with the approval and implementation of the new policy, the revised Special Needs Prescription Charge Voucher can be used throughout the medical system. Combined, the new forms will facilitate identification of ineligible patients as well as document the requesting department and social worker. The intent of these initiatives is to allow the implementation of one of the cost allocation methods recommended below. The importance of this information will be discussed later in this document.

Data Collection and Analysis

Data were collected from actual prescription charge vouchers for the months of July and August 1997. Each charge voucher was reviewed for patient demographics, fill date of prescription, the medication(s) dispensed and the respective cost of those medication(s), and insurance status. Appendix D provides the summary of patient demographics of the analyzed sample. A total of 362 patient encounters were studied representing 852 prescriptions. On average, approximately six vouchers are processed every day. The total cost of the prescriptions provided free of charge to patients during this time period was $25,383 which included $2,556 in dispensing fees. The average age of a SNP recipient was 40 years, with a range of 87 years. Patients received, on average, 2 prescriptions per voucher

From the listing of medications dispensed, a monthly summary of drug cost was developed and distributed to the social workers involved in the program. The intent of this effort was to increase awareness about the cost of medications to promote the use of less expensive drugs in the prescribing patterns. A booklet, an example of which is found in Appendix E, was given to the Social Work service head in each area. They, in turn, will use the booklet to check the cost of each medication on a voucher to explore lower cost drug options.

Regarding eligibility, the insurance status of SNP recipients was verified by reviewing each patient's financial account. Using the hospital's Keane Accounting System, it was found that approximately 34% (108) of the recipients had some form of insurance that would have covered at least partially the costs of their prescription drugs (Medicare recipients were excluded). From the sample, a total savings of $7,163 (28%) in medication costs could have been realized had appropriate insurance verification been performed by the Social Work staff.

Next, using the new policy as a guideline, the SNP list was reviewed for potential exclusions to the medications as outlined in the new regulations. Had the medications that are now

limited based on the stringent eligibility guidelines been disapproved, a savings of $9,800 would have been achieved.

To review the hospital's application processing method for the state Medical Assistance Program, the activities of the Medical Assistance Team were reviewed. This team, working out of the Patient Accounting Division of Finance, meets with each patient designated as "self pay" during the admission process. The patient is queried about his or her ability to meet the financial demands of hospitalization. If it is determined that the patient may have difficulties in meeting the demands, the application process is initiated. If the patient is seen on an outpatient basis or in the Emergency Department, the patient is referred to the Social Worker or Medical Assistance Office. Because the process relies heavily on patient participation and cooperation, as well as the response time from the State of Maryland, specific improvements to this process are outside the scope of this project and have not been considered. Thus, the data collected and resulting recommendations can be considered internal actions to be considered by The Johns Hopkins Hospital.

The last data set collected relates to the policies and practices of other local hospitals in Baltimore City. Appendix F summarizes the findings. The Johns Hopkins Hospital is not the only hospital in Baltimore that provides free prescription medications to indigent patients and fully absorbs the costs. The Mercy Medical Center also offers a similar service to indigent patients and absorbs the cost through a charitable loss recorded in their Finance Division. Similarly, the University of Maryland Medical Center and Greater Baltimore Medical Center provide free medications, but fund their programs through grants from undisclosed sources. Two other hospitals, the Good Samaritan and Church Hospitals, have designated charity funds under which their programs operate. Good Samaritan has a fund specifically designated to provide free prescription medications, while the Church Hospital uses a multipurpose charity fund to provide the service. Other hospitals either refer patients directly to the state Medical Assistance Office for application

processing or do not have specific programs to provide prescription medications. All but one hospital were unable or unwilling to provide cost estimates on their respective programs.

CONCLUSIONS AND RECOMMENDATIONS

Recipient Tracking and Database Development

While the revisions to this program remain an ongoing process, several conclusions can be made from the data analyzed thus far. Related to the administration of the program, the method of identifying and tracking SNP recipients is not sufficient to allow accurate, easy data collection, retrieval and analysis. As a result of this conclusion, a computer software tracking program was developed and implemented in the Patient Relations Central Office. Using existing computer resources, a customized program was written in Microsoft Access® that will be used to record SNP patient demographics, eligibility status (as verified through the state), insurance status, the cost of prescription medications dispensed, and document social work staff usage patterns and trends. This information can be used to develop a cost allocation method that is equitable, such as assigning the costs to the respective functional unit of the social worker submitting the SNP voucher, should alternate financing not be secured. Additionally, this database will allow the SNP point of contact in the Central Office to retrieve and verify eligibility status in a more timely manner, thereby preventing the occurrence of multiple vouchers approved on any single patient.

Cost Allocation

Due to the continually increasing costs of the program, the allocation method of attributing the costs to the Pharmacy cannot be maintained at the current level. From the collected data, it is apparent the program lacks sufficient administrative control to significantly reduce the financial impact on the Pharmacy's budget. Accountability must become the cornerstone of managing this service. The new policy builds accountability into the program by requiring the social worker

submitting the request for medications to document their name and department on the voucher and assessment form. As stated above, this information can then be used to appropriately allocate the costs of the SNP Program to the designated cost center. Further, the new policy restricts the availability of over-the-counter and "non-life sustaining" medications that have historically increased the program's cost.

Regarding the process of cost attribution, there are several options to consider in revising the methodology. The most equitable method would be to track the occurrence of SNP vouchers by functional unit and then expense the costs directly to the functional unit. This would spread the costs of the program over several functional units and virtually eliminate the financial impact on the Pharmacy. Although it would involve meticulous financial and budget planning at the functional unit level, this action would serve as a motivating factor to decrease the overall costs of the program. If alternate financing is not secured, it is recommended this direct apportionment method of allocating costs be implemented.

Another option to consider is to plan for these costs as expenses (approximately $250,000 per year) in either the Social Work, Pharmacy, or Patient Relations budgets for the fiscal years forthcoming. Again, this would require involved financial and budget planning, but force efforts to reduce the costs of the program. Unfortunately, the end result of either of the above actions would be a net loss to the operating budget, as the expense of the program does not involve direct revenue return to the organization and cannot be included in the charges generated by the hospital.

Alternate Financing Options

The most logical solution to the financing problem is to acquire funds to support the program from a source other than the hospital budget. Unofficial inquiries into the possibility of financial support from the United Way and The Johns Hopkins Women's Board were made. These charities were unable to provide funding at this time. Fortunately, the literature review and local

hospital survey provided an attractive option. The "designated funds" concept used by both Church and Good Samaritan Hospitals is a method of alternative financing that would eliminate the financial burden on the hospital. Additionally, research conducted by the Advisory Board (1997) found a hospital that developed a charity fund to which employees can contribute to finance prescription medications for indigent patients. This concept will be forwarded (in January 1998) to The Johns Hopkins Hospital Fund for development and feasibility planning.

Eligibility Verification

The data analysis of the prescription vouchers showed approximately 34% of recipients of SNP vouchers had some form of insurance that would cover at least part of the cost of their prescription medications. Thus, the method of eligibility verification related to insurance coverage is insufficient to assure only patients who are in true need of free medications receive vouchers. The implementation of the new policy and database tracking system will drastically reduce this occurrence, as insurance and eligibility verification are required in order for the prescriptions to be filled. Additionally, accountability for prudent fiscal management is inherent in the new policy and associated required documentation. This data will be tracked through the Patient Relations Central Office in the SNP Voucher software program.

Program Coordination

Until this point, there has been minimal program coordination between the involved departments. Multiple functional units were attempting to coordinate different components of the program. This may be counterproductive to effective management and hinder efforts to instill administrative and financial control. Therefore, it is recommended that one single point of contact (POC) (one FTE) be assigned to coordinate, track and analyze the Special Needs Prescription Program. The position should be created in the Patient Relations Central Office, which is ideally located and equipped to manage the program. The Director of Patient and Visitor Services has been

informed of this recommendation and has agreed to assign this program to one individual in January 1998 in conjunction with the new policy publication and implementation. The assignee (SNP POC) will be responsible for database management, eligibility verification, voucher/assessment coordination and filing, and future education and communication efforts about the program. By delegating this responsibility to one single point of contact, the "corporate knowledge" about the SNP Program will be developed allowing the organization to better manage the costs.

COMMUNICATION PLAN

Communication of the revisions to the policy and essential need for cost control are paramount to the successful implementation and ongoing future efforts of staff involved in the administration of the SNP Program. On December 9, 1997, a meeting was held with the heads of the Social Work Departments, Pharmacy and Central Office representatives to present the new policy and discuss the future initiatives to control costs. The policy was well received, and will be distributed to all individuals who administer the program. Appendix E was also distributed and well received. Additional education efforts such as forwarding the policy to all units and residents, an addendum statement to the Resident's Handbook, and an information point of contact have been arranged and will be implemented in January 1998.

LIMITATIONS OF THE PROJECT

Despite the initiatives taken thus far, there are several limitations in the revisions made to the program. The data analysis phase gathered only a representative sample of 2 months of Special Needs Vouchers. Due to the limited time and scope of the project, the data were not seasonalized to consider higher volume months such as December through April. This may have the effect to understate the actual costs of the program, as colder seasons generally involve diseases like

pneumonia, ear infections and the flu. These diseases tend to increase the amount of prescription medications ordered and could result in higher program costs.

This project did not address detailed clinical implications to the SNP Program revisions, such as requiring generic medications or lower cost medication alternatives. For example, the most frequently prescribed antibiotics during July and August 1997 were Ciprofloxin, Cephalexin and Clindamycin. These drugs are "high end" broad spectrum antibiotics that are very expensive. Additional research should be conducted by either the Medical Staff or Pharmacy to find lower cost alternatives that are as efficacious as these drugs. This element of program revision should be considered in future efforts, as approaching clinician practice patterns requires actions beyond the scope of this project.

It should be noted that efforts to involve the State of Maryland Medical Assistance/ Pharmacy Assistance Offices were met with resistance. There may be improvement opportunities that exist in the application approval/denial process at the state level that would facilitate eligibility verification efforts internal to The Johns Hopkins Hospital. Although the Hopkins' Medical Assistance team sees every patient designated as "self pay" on admission, the application process for MA/PA is dependent on the respective patient's cooperation with the state offices. The newly designated SNP POC may be well suited to work in conjunction with the State of Maryland to initiate improvements in their processes.

Finally, a memorandum issued on November 25, 1997 at The Johns Hopkins Hospital stated that the Balmer Pharmacy, the pharmacy that fills approximately 90% of the special needs prescriptions, will close in the Spring of 1998. When this happens, it will significantly impact the SNP Program. A meeting was held representatives of the Patient Relations Central Office, Social Work, and Pharmacy to discuss the development of an action plan. It was decided that the best course of action when Balmer Pharmacy closes, would be to work with other local pharmacies to

provide SNP assistance. Recognizing this effort would take at least a year to implement and require planning and approval, the members present agreed that the SNP Program must not be "lost in the shuffle." The policy revision and education plan development from this project were noted as a possible solutions to prevent such an occurrence.

MARYLAND PHARMACY ASSISTANCE PROGRAM

CURRENT INCOME/ASSET SCALES

Effective January, 1997

NUMBER OF PERSONS IN HOUSEHOLD UNIT	GROSS INCOME YEARLY	GROSS INCOME MONTHLY	ASSET SCALE
1	$ 9,050	$ 754.16	$ 3,750
2	$ 9,800	$ 816.66	$ 4,500
3	$ 10,750	$ 895.83	$ 4,650
4	$ 11,550	$ 962.50	$ 4,800
5	$ 12,350	$ 1,029.16	$ 4, 950
6	$ 13,100	$ 1,091.66	$ 5,100
7	$ 14,200	$ 1,183.33	$ 5,250
8	$ 15,200	$ 1,266.66	$ 5,400
9	$ 16,350	$ 1,362.50	$ 5,550
10	$ 17,250	$ 1,437.50	$ 5,700
EACH ADDITIONAL PERSON	$ 1,150		

SOCIAL SECURITY C.O.L.A. INCREASE - 2.9%

****

THERE ARE NO EXCEPTIONS TO THE ABOVE INCOME/ASSET SCALE. THE MARYLAND PHARMACY ASSISTANCE PROGRAM DOES NOT CONSIDER AGE, EXPENSES, OR MEDICAL CONDITION AS A CRITERIA FOR DETERMINING ELIGIBILITY.

APPENDIX A

SNP Project Timeline Summary

Project Task	Point of Contact	Estimated Completion Date	Implementation Date
Interview Key Personnel	S. Seville, H. Hamet, F. Quarle	02 Sept 97	N/A
Complete Access Dbase Tracking System	F. Quarle	09 Sep 97	09 Sep 97
Review and Revise Current Policy	H. Hamet, S. Seville	10 Sep 97	1Oct 97
Collect Current Data on SNP Vouchers	H. Hamet	15 Sep 97	N/A
Complete Medication Profile Cost Booklet	S. Seville	30 Sep 97	30 Oct 97
Submit New Policies	T. Cunningham	01 Oct 97	19 Nov 97
Analyze Data Demographics and Trends		01 Nov 97	N/A
Report Patient Eligibility Status	T. Cunningham, L von Kessler	05 Nov 97	N/A
Conduct Telephone Survey of Local Hospitals		15 Nov 97	N/A
Develop Education Training Plan		30 Nov 97	20 Dec 97
Complete Project Proposal		30 Oct 97	29 Oct 97
Complete GMP Report		30 Dec 97	31 Dec 97

APPENDIX B

SPECIAL NEEDS PRESCRIPTIONS PROGRAM RULES AND REGULATIONS

PURPOSE

The purpose of the Special Needs Prescriptions Program is to assist patients in obtaining prescription medications during the processing time involved in applying for Medical Assistance/ Pharmacy Assistance with the State of Maryland.

POLICY

The Johns Hopkins Hospital Social Work Department will serve as a centralized location to provide prescription assistance via a "Special Needs Prescription Charge Voucher" to eligible patients as follows:

ELIGIBILITY CRITERIA (Patients receiving vouchers must meet at least one of the following):

1. A patient who has been determined to be in critical need of financial assistance with regard to the purchase of prescription medications as determined by a **DETAILED AND DOCUMENTED** assessment completed by the responsible physician and social worker and has applied or is in the process of applying to the Maryland State Medical/Pharmacy Assistance Program but not yet received an approval decision. Prescriptions in this category are limited to a 15 day supply.

2. Case-by-case consideration to individual patients whose eligibility or application status for Medical Assistance is unknown where prescriptions for "life-sustaining" or "critical" medications have been ordered. Medications classified as Cardiac Drugs (anti-arrhythmic, ACE Inhibitors, CA Channel Blockers, B Blockers), Antihypertensives, Anticoagulants, Antiseizure/ Antispasmodics, Diuretics, Insulins, Bronchdilators, and certain Psychotropic drugs are the only acceptable medications for waiver considerations. Prescriptions for these medications are limited to a ten-day dosing regimen.

DISQUALIFICATION AND DENIAL CRITERIA:

1. Any patient who received a "Special Needs" prescription within the last 12 months.
2. Patients who are not compliant with the Medical Assistance application process.
3. Substance abuse patients who are non-compliant with their Individual Treatment Plan.
4. Prescriptions for over-the-counter (OTC) drugs, topicals, shampoos, vitamins, or other supplements.
5. Prescriptions from non-JHH clinicians or non-JHH main facility clinics

APPENDIX C

6. Any patient that has private/commercial insurance, HMO, Blue Cross/Shield, Medicare, Medical Assistance or Pharmacy Assistance coverage.
7. The Special Needs Prescription Charge Voucher is not properly endorsed by a Social Worker from the Johns Hopkins Hospital.
8. Any durable medical equipment or supplies other than insulin syringes.
9. Medication to treat AIDS/HIV except when all other sources have been explored. These drugs are available through other funding programs.
10. Any Johns Hopkins Hospital employee.

EXCEPTIONS TO THE ONE TIME RULE:

A patient may be approved for one additional refill on a Special Needs prescription when, as validated by the Social Worker assigned to the case, it is determined that the patient is in full compliance with the MA/Maryland Pharmacy Assistance application procedures but their application has been delayed by or is in a pending status at the MA processing office.

PROCESSING

During normal business hours, only the centralized Special Needs point of contact located in the Social Work Department is authorized to complete and forward both the Special Needs Eligibility Evaluation Form and the Special Needs Prescription Charge Voucher. During the off hours, both forms will be completed by the Special Needs point of contact located in the Emergency Dept.

PROCEDURES

1. SOCIAL WORKER:
    a. Interviews the patient to determine financial need for prescription assistance.
    b. Completes the Special Needs Prescription Eligibility Evaluation Form and Charge Voucher as per the MD's/ provider's orders. A Social Worker's signature **must** be evident on the Prescription Charge Voucher for the medications to be dispensed.
    c. Directs patients to report to the Special Needs point of contact in the Social Work Department or Emergency Room (if after hours).

2. SPECIAL NEEDS POINT OF CONTACT:
    a. Completes eligibility form and verifies patient's eligibility.
    b. Notifies patient of their eligibility status and of funding limits.
    c. Completes Special Needs Prescriptions Charge Voucher for eligible patients.
    d. Receives approval/denial decision from the MA Office and initiates

reimbursement steps.

e. Maintains the Special Needs Patient database and generates program statistics.

3. CONTROLLING OFFICE:
   a. Ensures quarterly audits of 5% review are conducted and documented.
   b. Completes annual reports on cost/use of the Special Needs Program and on
      the Maryland Pharmacy Assistance Program approval/denial rate for patients
      who receive Special Needs prescriptions.

4. AUDITS:
   a. Verifies patients' eligibility decisions are tracked, reimbursed, and received
      for approved Special Needs accounts.
   b. Reviews Special Needs Prescription Charge Voucher for accuracy and completeness.
   c. Reviews Special Needs Eligibility Form for accuracy and completeness.
   d. Reviews Special Needs database for accuracy and completeness.
   e. Reviews Pharmacy audits on funding limitations, discount verification, and
      approved payments.

OFFICE OF CONTROL

Director of Patient and Visitor Services

COMMUNICATION

The Special Needs Prescription policies and procedures will be briefed to all new Social Workers and at the semiannual Social Work meetings. The Special Needs Point of Contact will inform all Social Work Department Managers of any program changes. The Department Managers will immediately inform the Social Workers of any program changes.

SPECIAL NEEDS PROGRAM REVIEW

The Special Needs policies and procedures will be reviewed annually by the Director of Patient and Visitor Services.

SPECIAL NEEDS PRESCRIPTION ELIGIBILITY EVALUATION

In order for a voucher to be authorized, a Social Worker must complete this form and enclose it with the voucher. This form does not take the place of a Social Work Assessment. **REMINDER:** *A voucher does not cover over-the-counter medications or copays. Major exceptions and refills are to be accompanied by a detailed explanation.*

Call EVS (333-3020). If the patient has prescription coverage, give the patient the number and stop here. *If not, continue to complete this form.*

PATIENT NAME _____ **LOCATION**_____
Last First MI

HISTORY #_____ **SOCIAL SECURITY #**_____

REASON FOR VOUCHER:

1. Verify the patient does not have insurance (Verify in Keane System).

2. Monthly household income insufficient to meet prescription costs? Yes ☐ No ☐

3. Has the patient had a voucher before? Yes ☐ No ☐ *If yes, exception/reasons must be noted*

   _____

4. Has the patient applied or been given the application for Medical Assistance?

   Yes ☐ No ☐ *If no, explain the rationale below*

   _____

   _____

5. Was a voucher given? Yes ☐ No ☐

   Social Worker: _____

   M/S ☐ ED ☐ Psych ☐
   Moore ☐ Pediatrics ☐

Total Cost		
Mean	$	70
Standard Error	$	5
Median	$	43
Mode	$	34
Range	$	798
Minimum	$	3
Maximum	$	801
Sum	$	25,383
Count		362

# RXs	
Mean	2
Standard Error	0
Median	2
Mode	1
Range	7
Minimum	1
Maximum	8
Sum	852
Count	362

Age Stats	
Mean	40
Median	40
Mode	76
Range	87
Minimum	0
Maximum	87.8
Count	362

Summary: The average cost to the hospital per SNP Voucher is $70, with a median cost of $43. The average age of an SNP recipient is 40 years, but recipient age ranges from birth to 88 years. There are two prescription medications filled per voucher, on average, with a range from 1 to seven per voucher.

APPENDIX D

Drugs	Average Cost	Alt/Generic
Acetazolamide 250	$ 16.44	
Acyclovir 200	$ 14.46	
Acyclovir 400	$ 48.50	
Acyclovir 800	$ 47.24	
Aerobid-M Inh	$ 54.18	
Albuterol Inhaler	$ 20.17	
Albuterol Nebs Soln	$ 28.60	
Aldactone 100	$ 19.63	
Aldactone 25	$ 5.25	
Allopurinol 100	$ 4.62	
Amoxicillin 250	$ 6.54	
Amoxicillin Cap 500	$ 12.14	
Amoxicillin Susp 125/5	$ 5.78	
Ampicillin 500	$ 5.22	
APAP w/Cod Elix 12mg/5	$ 5.37	
Apap/Cod #3 30 mg	$ 6.02	
Atenolol 100	$ 14.83	
Atenolol 25	$ 10.20	
Atenolol 50	$ 11.10	
Atrovent inh	$ 31.34	
Augmentin Tabs 500	$ 85.58	
Azmacort Inhaler	$ 43.96	
B-Complex +	$ 4.76	
Clindamycin 150	$ 73.30	
Clonazepam 1	$ 32.06	
Clonidine .1	$ 3.66	
Clonidine .3	$ 9.58	
Clotrimazole Cream 1%	$ 18.43	
Cogentin 2	$ 6.05	
Colace 100	$ 3.57	
Colchicine .6	$ 3.32	
Coumadin 1	$ 25.91	
Coumadin 5	$ 11.33	

Drugs	Ave $	Alt/Generic
Baclofen 10	$ 15.10	
Baclofen 20	$ 9.91	
Bactrim DS	$ 11.68	
Beclovent Inh	$ 34.36	
Benztropine .5	$ 4.68	
Benztropine 1	$ 5.42	
Biaxin Susp 250/5	$ 50.85	
Brethine 2.5	$ 10.42	
Captopril 12.5	$ 13.88	
Captopril 25	$ 26.50	
Cardiazem CD 180	$ 39.71	
Cardiazem CD 240	$ 27.81	
Catapres TTS Patch .2/DA	$ 51.82	
Cefadroxil 500	$ 47.10	
Ceftin 500	$122.97	
Cephalexin 250	$ 9.66	
Cephalexin 500	$ 41.43	
Cephalexin Susp 125/5	$ 9.36	
Cholestry Powder	$ 31.28	
Chromagen FA	$ 7.06	
Cimetidine 400	$ 36.34	
Cipro 250	$ 41.31	
Cipro 500	$ 90.50	
Cipro 750	$130.47	
Dilantin 100	$ 10.88	
Dilaudid 2	$ 11.38	
Diltiazem 30	$ 22.39	
Disulfiram 250	$ 4.00	
Doxcycline 100	$ 11.74	
Drocli Syrup	$ 11.14	
Dynapen Susp 62.5/5	$ 26.71	
Elimite Cream 5%	$ 23.29	
Epivir Oral Soln 10mg/ml	$ 58.36	

Cost includes the $3.00 per drug dispensing fee

Costs are based on averages from the total sample of 852 prescriptions dispensed

APPENDIX E

Drugs	Average Cost	Alt/Generic	Drugs	Ave $	Alt/Generic
Cyclobenzaprine 10	$ 34.00		ERY-Tab 333	$ 11.64	
Deltasone 2.5	$ 3.80		Eskalith CR 450	$ 13.62	
Depakote 250	$ 60.39		Estradiol 1	$ 6.65	
Depakote 500	$ 36.42		Ferrous Sulfate 325	$ 7.54	
Desyrel 50	$ 7.41		Flucinonide Soln .05%	$ 22.20	
Dexomethasone .5	$ 4.64		Folic Acid 1	$ 3.34	
Diamox 500	$ 31.39		Fosamax 10	$ 27.12	
Diazepam 5	$ 5.10		Gemfibrozil 600	$ 26.84	
Dicloxacillin 250	$ 19.81		Glaucon Opth Soln	$ 24.42	
Dicloxacillin 500	$ 23.82		Glyburide 2.5	$ 6.60	
Dicyclomine 20	$ 7.79		Glyburide 5	$ 21.36	
Diflucan 100	$ 102.11		Grifulvin V Susp 125/5	$ 70.63	
Diflucan 50	$ 42.42		Grisactin Cap 250	$ 13.72	
Digoxin .125	$ 5.38		Haloperidol 1	$ 9.26	
Digoxin .25	$ 5.83		HC Cream	$ 4.92	
Humulin 70/30	$ 20.88		HCTZ 25	$ 3.47	
Humulin N	$ 20.23		Humulin 100u	$ 20.88	
Humulin NPH	$ 20.88		Lasix 80 mg	$ 8.83	
Humulin R	$ 20.88		Levoxyl .15	$ 4.86	
Hydroxychloroquine 200	$ 29.30		Lindane Lotion	$ 6.05	
Hytrin 2	$ 22.01		Lindane Shampoo 1%	$ 9.56	
Ibuprofen 600	$ 7.26		Lithium 300	$ 7.03	
Ibuprofen 800	$ 8.84		Livostin Opth Oint .05%	$ 29.24	
Imdur 30	$ 17.61		Lopidine .5	$ 36.47	
Imdur 60	$ 32.53		Lotrimin Lotion 1%	$ 25.22	
Imipramine 50	$ 5.06		Lotrisone Cream	$ 21.05	
Imitrex 25	$ 294.17		Mepron Susp 750/5	$488.36	
Invirase 200	$ 178.81		Methazolamide 50	$ 45.40	
Isoniazid 300	$ 4.00		Methylpred Dospak 4	$ 11.71	
Isosorbide 10	$ 4.77		Metoclopramide 10	$ 11.31	
K-Dur 20	$ 24.74		Metoprolol 100	$ 18.06	
Kdur 20 meq	$ 6.11		Metoprolol 50	$ 9.14	
Klor-con Tabs	$ 7.36		Metronidazole 250	$ 7.82	

Cost includes the $3.00 per drug dispensing fee

Costs are based on averages from the total sample of 852 prescriptions dispensed

APPENDIX E

Drugs	Average Cost	Alt/Generic	Drugs	Ave $	Alt/Generic
Lactulose Syrup 10g/15	$ 85.48		Metronidazole 500	$ 14.16	
Lactulose Syrup 25	$ 80.71		Mevacor 20	$ 48.60	
Lamictal 25	$ 61.97		Monopril 10	$ 12.85	
Lasix 20	$ 4.35		MS Contin 30	$142.27	
Lasix 40	$ 4.07		MVI	$ 3.71	
Otocort Otic Susp	$ 11.07		Myambutol 100	$ 10.21	
Oxazepam 10	$ 9.84		Myambutol 400	$147.79	
Oxazepam 30	$ 5.79		Mycobutin Susp 10/ml	$ 41.78	
Oxycodone/Apap 5/500	$ 16.92		Nadolol 20	$ 9.37	
Oxycontin 10	$ 22.87		Naproxen 375	$ 23.69	
Paxil 20	$ 30.91		Nephrolan RX	$ 7.47	
PenVK 500	$ 10.36		Neptazam 50	$ 32.16	
Pepcid 20	$ 46.66		Nifedipine 10	$ 19.38	
Phenergan Supp 25	$ 79.34		Nifedipine 20	$ 34.14	
Phenobarb 30 mg	$ 4.39		Nitro-dur .6mg/hr	$ 50.50	
Phenobarbitol 60	$ 4.37		Nortripltyline 25	$ 11.99	
Phoslo 667	$ 8.18		Norvasc 10	$ 31.50	
Pilocarpine 1%	$ 6.99		Norvir 100	$203.57	
Pilocarpine OP Soln	$ 10.77		Nystantin Oint 100/gm	$ 6.19	
Pn VK 500	$ 9.99		Nystantin Oral Susp	$ 35.50	
Prednisone 10	$ 4.05		Ocupress 1%	$ 19.35	
Prednisone 20	$ 5.77		Otocort Otic Susp	$ 11.07	
Prednisone 5	$ 5.51		Prilosec 20	$ 53.00	
Prelone Syrup	$ 14.06		Prinivil 20 mg	$ 27.36	
Premarin .625	$ 9.09		Prinivil 5	$ 14.04	
Prilosec 20	$ 102.36		Procardia XL 30	$ 20.45	
Sulfatrim Susp 200/40	$ 5.36		Procardia XL 60	$ 40.50	
Syringes	$ 9.22		Procardia XL 90	$ 38.57	
TAC Cream 1%	$ 7.09		Prolexin 10	$ 31.31	
Temazepam 15	$ 6.83		Prolulsid 10	$ 36.74	
Theo-dur 300	$ 12.64		Propanolol 10	$ 7.04	
Thiamin 100	$ 3.40		Prozac 20	$ 34.00	
Thioridazine 100	$ 9.18		Pyrazinamide 500	$ 63.68	

Cost includes the $3.00 per drug dispensing fee

Costs are based on averages from the total sample of 852 prescriptions dispensed

APPENDIX E

Drugs	Average Cost	Alt/Generic
Thioridazine 25	$ 6.28	
Thoridazine 25	$ 12.83	
Ticlid 250	$ 48.14	
Timolol .5	$ 18.35	
Toprol XL 100	$ 12.59	
Trazodone 150	$ 14.62	
Trazodone 50	$ 6.12	
Triamt/HCTZ	$ 13.72	
Trifluoperazine 5	$ 48.78	
Trimeth/Sulf/Poly OP	$ 16.94	
Tylox	$ 22.80	
Valproic Acid 250	$ 16.00	
Valproic Acid Syrup 250/5	$ 23.75	
Vasotec 10	$ 31.91	
Vasotec 5	$ 30.54	
Verapamil SR 180	$ 15.66	
Verapamil SR 240	$ 26.98	
Verelan 240	$ 22.29	
Videx 100	$ 90.21	
Videx Peds powder	$ 32.08	
Viramune 200	$ 114.58	

Drugs	Ave $	Alt/Generic
Retrovir 300	$132.17	
Rifadin 300	$ 71.40	
Rimactane 300	$ 50.02	
Rocaltrol .25 mcg	$ 19.02	
Roxicet	$ 19.73	
Roxicodene Soln	$ 25.49	
Serzone 100	$ 57.56	
SMZ-TMP DS 800/160	$ 8.22	
Spectazole Cream 1%	$ 22.08	
Spironolacto 25 mg	$ 7.49	
Sporanox 100	$338.74	
SSD Cream 1%	$ 7.68	
Sulcrafate 1 gm	$ 39.72	
Sulfasalazine 500	$ 15.90	
Sulfatrim Ped Susp	$ 4.18	
VR DIS syrup	$ 9.48	
Xalatan .005%	$ 38.40	
Zantac 15 mg/ml	$109.60	
Zantac 150	$ 38.75	
Zantac Syrup 15/ml	$ 38.05	
Zerit 15	$ 51.76	
Zerit 20	$ 97.65	
Zerit 40	$112.71	
Zestril 10	$ 14.41	
Zithromax 250	$ 59.03	
Zoloft 25	$ 31.18	
Zoloft 50	$ 47.67	
Zyprexa 10	$110.63	
Zyrexene 10	$ 31.70	
Zyrexene 5	$ 36.04	

Cost includes the $3.00 per drug dispensing fee

Costs are based on averages from the total sample of 852 prescriptions dispensed

APPENDIX E

Hospital Prescription Assistance Programs in Baltimore			
Hospital	Specific Program	Funding	Comments
Church Hospital	Yes	Multipurpose Charity Fund	Considered a high cost program, loose control
Crain Medical Center	No	Meds obtained through drug companies	
Good Samaritan	Yes	Specific designated charity fund	Flexible in management
Greater Baltimore Medical Center	Yes	Grant Funded	
Harbor Hospital	Yes	Charitable Loss taken	
Hilton Community Medical Center	No	Patient's responsibility	
Jai Medical Center	No	Patient's responsibility	
Mercy Medical Center	Yes	Hospital takes a charitable loss	
Park West Medical Center	No		
Sinai Medical Center	N/A		Not willing to participate in survey
University Medical Center	Yes	Grant Funded	

Appendix F

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